

November 22, 2002

Re: Medical Dispute Resolution  
MDR #: M2.02.1176.01  
IRO Certificate No.: IRO 5055

Dear

In accordance with the requirement for TWCC to randomly assign cases to IROs, TWCC assigned your case to \_\_\_\_ for an independent review. \_\_\_\_ has performed an independent review of the medical records to determine medical necessity. In performing this review, \_\_\_\_ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

The independent review was performed by a matched peer with the treating health care provider. Your case was reviewed by a physician who is Board Certified in Orthopedics and Spinal Surgery.

Clinical History:

This claimant is a 55-year-old female who was injured on her job on \_\_\_\_\_. She underwent L4-5 fusion on 05/25/00, after presenting with persistent back pain and bilateral anterior thigh pain, which had not responded to conservative measures.

Disputed Services:

L3-4 fusion.

Decision:

The reviewer agrees with the determination of the insurance carrier. The reviewer is of the opinion that the procedure in question is not medically necessary in this case.

Rationale for Decision:

The radiology reports of 09/05/01 reveal degenerative disc disease at L1-2, L2-3 and L3-4. The radiology report of 05/07/01 reveals only mild L3-4 spinal stenosis to be present. Based on this information, it would be impossible to determine the etiology of this patient's back pain. Further evaluation and/or testing of the patient are required to better determine this patient's pain generator.

I am the Secretary and General Counsel of \_\_\_\_ and I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care

providers who reviewed this care for determination prior to referral to the Independent Review Organization.

We are simultaneously forwarding copies of this report to the payor and the Texas Workers' Compensation Commission. This decision by \_\_\_\_ is deemed to be a Commission decision and order.

### **YOUR RIGHT TO REQUEST A HEARING**

Either party to this medical dispute may disagree with all or part of this decision and has a right to request a hearing.

**If disputing a spinal surgery prospective decision** a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings **within ten (10) days** of your receipt of this decision (28 Tex. Admin. Code 142.5©).

**If disputing other prospective medical necessity** (preauthorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings **within twenty (20) days** of your receipt of this decision (28 Tex. Admin. Code 148.3).

This Decision is deemed received by you **five (5) days** after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5 (d)). A request for a hearing should be sent to:

Chief Clerk of Proceedings  
Texas Workers' Compensation Commission  
P.O. Box 40669  
Austin, TX 78704-0012

A copy of this decision should be attached to the request. The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute.

I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on November 22, 2002.

Sincerely,